The Pickering Report, Part II: what the doctors think

CMAJ presents the second part of the Pickering Report, which is being published verbatim in series. As explained in Part I, the report is the result of a $200,000 independent study of the medical profession in Ontario and its relationships with the public and government. It was carried out by retired industrialist Edward A. Pickering and although the project was commissioned by the Ontario Medical Association, Mr. Pickering was given total freedom to conduct the study as he saw fit and bring in such recommendations as he, in his sole judgement, considered appropriate.

It was obviously important that an attempt be made to get a quantifiable self-portrait of the doctor — his attitudes, his workstyle, his background, his costs.

Since the association regularly surveys its membership through its own mailing list, it was decided to conduct the physicians' survey by mail.

The gross sample frame was a 50% systematic sampling from a random starting point of the OMA mailing list. This yielded a sample of 6500 to whom questionnaires were mailed.

The OMA mailing list included nonmembers; 91.7% of the sample are members of the OMA.

Because the questionnaire is a long one almost two months were allowed for response. We received 1496 anonymous responses by the cut-off date (23%). This is, of course, not an insignificant sample compared to the total doctor population of 13,000.

However, in order to establish whether or not the responses are representative, follow-up surveys in person or by telephone are necessary to identify non-responders and to attempt to secure data from a cross-section of these non-responders. Limits of time prevented us from undertaking this follow-up research at this time.

Because of the reservations about the degree to which the data are representative, the findings should be approached with caution. The tabulations provide some potentially important sociological information of a kind which has not been obtained before but which should be available on a continuing basis if the role of the physician is to be understood.

The findings may not be precisely representative, but they do provide a body of factual information based on responses from a significant sample of physicians. The findings are revealing though not always encouraging.

The questions covered attitudes, workstyle, educational background and a variety of other basic data.

What follows is a discussion of the key findings of the survey.

Physicians' attitudes

To find out how doctors feel about the medical profession, we asked to what degree the respondents would encourage or discourage young people from entering the profession.

Of those who responded, 28.9% would encourage young people enthusiastically and 47.8% would encourage somewhat. But over one-fifth of the doctor population would discourage somewhat (18.1%) or discourage strongly (3.9%). Almost half the respondents (48.1%) were in the 35-49 age group. And this group represented 55.2% of those who would discourage somewhat and 61% of those who would discourage strongly. Of this group 26.2%, over one-quarter, would either somewhat or strongly discourage young people from entering the profession. These figures hardly indicate a smug satisfaction in the rewards of the profession, particularly among the middle-aged respondents.

Doctors agree with the general public's feeling that respect for the profession is decreasing, only more so. Two-thirds of the respondents (63.2%) feel

that public respect is decreasing and only 1.9% feel respect is increasing. 33.8% believe there is no change.

85.2% of the doctors feel that laymen have more influence today than they used to on professional matters; but 44.3% feel that laymen have about the right amount of influence and 9.1% feel they have too little influence. 45.1% feel that laymen have too much influence.

The shift to group practice is clearly seen. 92% agree there will be more doctors in group practice 10 years from now. In the 35-49 age group 94.1% feel this way.

Over two-thirds (69.2%) feel that professional incomes in their fields of practice, relative to other occupations, will be less 10 years from now.

62.4% feel increasing presence of government in the medical profession is either a somewhat bad thing (39.5%) or a very bad thing (22.9%). 60.5% think medicare has resulted in the public either feeling somewhat more negative about physicians (43.5%) or much more negative (17.0%).

29.4% of the doctors themselves feel that they are not able to give their patients enough time, and 26.6% of them sense that their patients are aware of this.

More doctors feel that their service to patients has deteriorated rather than improved as a result of medicare, though 61.3% feel that service is about the same.

Over half the respondents (52.4%) agree that medical schools are admitting too few students to produce an adequate future supply of doctors in Ontario. 38.2% feel admissions are about right; 5.1% that too many students are admitted. This rather contradicts the popularly held view that doctors wish to keep down admissions.

The picture which emerges from this section is one of a disturbed profession, one whose members are far from entirely sure that it is a good profession to be in, who see their relative economic position declining in the future and who are concerned with erosion of public respect caused by factors not entirely within their control.

Sensitive to erosion of public respect, doctors may very well feel that they are vulnerable because they are today at the pinnacle of socioeconomic position with nowhere to go but down in changing society.

There is an awareness of the problem of the time which is given to patients and there is concern about the effects which medicare and government involvement have had on the profession and on patient/doctor relationships. At the same time it must be noted that more doctors feel government's involvement is a somewhat good thing (24.8%) than feel it is a very bad thing (22.9%). But few (8.5%) are neutral, and 72.4% lean to negative feelings about government involvement. This is in contrast to the fact that feelings do not run nearly as strong against lay involvement in professional matters. It is the way in which government involves itself which appears to cause most concern.

Separate patient contacts in a week, of one kind or another — other than telephone calls — made by the average doctor were 195.8. Since the mean of days worked in a week was 5.9, the number of patient contacts works out at 33.2 patients a day. Of the patients seen in a week, 88.8 or 45.4% were seen in the doctor's office. By far the most frequent contacts were office visits. 56.6% of patients were referrals from another doctor. In addition to direct contacts there were 43.5 telephone calls per week.

Far more of these doctors (70.7%) accept night telephone calls than make housecalls (48.1%) though in the latter case the question was not relevant to the practice of almost a third of the responding doctors.

Incidentally, OHIP makes no payments to doctors for services rendered over the telephone.

Holidays of three to four weeks are the most frequent and the mean hours worked in an average week is 55.4, ranging up to a maximum of 97 hours — about 9.2 hours a day, six days a week on the average.

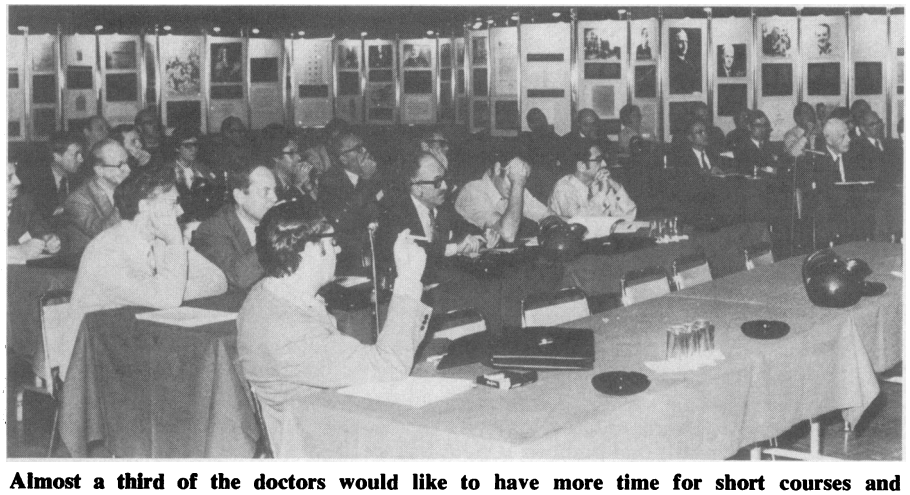
Interestingly enough the mean for various activities during an average 24-hour day shows 7.7 hours of sleep and 5.6 hours for personal and family activity which would not appear far from the norm in other occupations. Attending patients in the office is the most time-consuming professional activity at a mean of 6.1 hours.

Reading professional journals and books takes up over twice as much time in a month as any other preferred method of keeping up. Professional meetings are the next most preferred and almost a third of the doctors (31.7%) would like to have more time to attend courses; 28.7% would like to have more time for reading.

Of the respondents, almost half (47.1%) are in solo practice with no assistant, 12.9% in small partnerships, 21.2% in one-specialty group practices and 7.8% in mixed-specialty groups.

The mean of nine hours a day, six days a week, for this sample indicates a heavier work load than in most other callings. And it must be remembered that though this sample spent a more or less normal mean time on personal and family activities during the course of an average day, it was deprived of one whole day for these activities.

There is clearly a desire to spend more time on professional development, particularly on courses. Equally clearly, the time is not available.



Almost a third of the doctors would like to have more time for short courses and workshops.

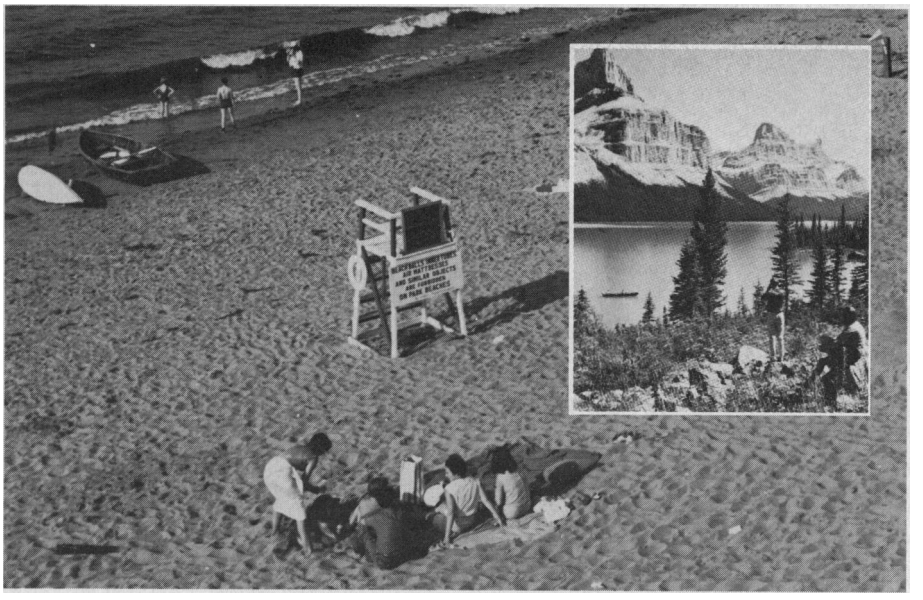
Educational background

Of the respondents, almost half (46.8%) have a specialty recognized by the Royal College; 29.5% have a basic medical degree only. The balance had other qualifications of one kind or another.

For reasons which are not clear, there appears to have been resistance to answering questions about where education was obtained and why it was obtained outside Ontario or Canada. But those who did reply confirm that an unduly high percentage of our doctors do not get their postgraduate medical training in Ontario.

53.5% got their medical training in Canada, 26.0% outside Canada; 20.5% did not state. Of those who were Canadian-trained, 57.7% were trained in Ontario. The next highest source was Quebec (6.7%), followed by British Columbia (1.3%) and Manitoba (1.1%); 31% did not state.

Of those who did not take their



Holidays averaged three to four weeks

medical training in Ontario (42.3%); 42.0% were new immigrants; 12.8% were living in other provinces; 1.7% could not get into Ontario medical schools and 14.4% decided that a school outside Ontario offered a superior faculty.

This, as do other data, again raises the question about Ontario's dependence on outside sources for supply of doctors. If those sources, for one reason or another, were to dry up, Ontario would have serious difficulties meeting the demand for new doctors.

Basic data

These data are of secondary interest, but they can be useful in future for more detailed analyses.

31.4% of respondents practise in the OMA's Toronto district, followed by 12.5% in the Niagara/St. Catharines/Hamilton district and 10.5% in the Ottawa district.

37.4% are in general practice, followed by 7.5% in psychiatry, 6.6% in internal medicine and 5.5% in general surgery.

91.1% are married and 92.0% are male.

54.7% of the respondents did not enter private practice (subsequent to internship and residency) until they were between 27 and 32 years. 40.3% entered practice when they were between 30 and 35; 27.9% started practising between 30 and 32 years.

The mean annual cost to the respondents of providing for retirement is $4221.

An interesting finding of this section is that over half (55.3%) of the respondents (only 3.1% did not respond) plan to retire at 65 or older. 26.6% plan to retire between 60 and 64. 17.1% have no financial provisions for retirement. 17.1% expect to retire at less than 30-39% of their present income, followed by 15.2% at less than 20-29% of present income. 24.3% expect their retirement income to be between 40 and 60% of present earnings.

This at a time when the business world is fast lowering the normal retirement age and encouraging early retirement. Doctors clearly have to wait longer than many other professionals to start earning substantial income and tend to work later in life. Only 15% expect to be able to retire before the age of 60. All this hardly suggests a quick financial killing in a doctor's working years in private practice. It can be argued that doctors have the advantage of not being forced into premature retirement, while their ability to serve effectively is still strong. But whether a longer working life is a matter of choice or force of circumstance is open to question.

Statistical papers

The volume of statistical data of various kinds runs to 73 pages and includes 51 tables. This wealth of material was compiled by Tom Foulkes of Price Waterhouse Associates in consultation with A. Peter Ruderman.

Much of the information is in the public domain and has been published elsewhere. But some of the information was especially compiled for this study and was designed to answer questions which the study team asked itself at the outset.

While some of the statistics are not specifically germane to the study, they are of general interest and some represent a quite new form of information. It is hoped that this material will be useful to other researchers. The main user of these data was Professor Ruderman.

Many of the tables help correct misconceptions and enrich information available on a given subject. But as with all statistics, they must be handled with care, since raw data can be interpreted in almost any way a protagonist wishes.

For example the blunt and frequently made statements that there are not enough doctors and that not enough doctors are being produced may or may not be true. The public opinion survey tends to support the argument. But the argument must be tempered by and seen in the light of several sets of information.

Public hearings

As a means of obtaining public participation in the study, hearings were scheduled throughout the province. The general public and interested organizations were invited through paid advertisements and the news media to attend and present submissions.

The hearings were held at Kapuskasing, Thunder Bay and Sudbury in the north; Kingston and Ottawa in the east; Windsor, London and St. Catharines in western Ontario, and in Toronto. Members of the advisory council participated in all but one of the hearings.

A total of 204 formal submissions were made. In addition there were many informal presentations and discussions.

Although the participants had been provided in advance with the terms of reference, it was obviously often difficult to adhere to them. It became apparent that the hearings represented a long-awaited opportunity for citizens from many walks of life to make their opinions and concerns known in a forum where, presumably, they would receive sympathetic audience. This strong public need to communicate to the profession is, perhaps, the single most important aspect of the hearings.

People have interesting and pertinent things to say to the profession and to government. When a channel of communication is opened, they are eager to use it. The trouble is that the channel provided by this study was only open for a short while. It is safe to say that there is a growing sense of public need for some formal mechanism through which constructive criticism and suggestion can be made known to those who can act on them. This will be dealt with more fully in the recommendations.

It is difficult to summarize adequately some 80 hours of oral representations and many more hours of reading and rereading over 200 sub-

missions. The submissions received came from a broad spectrum of persons and organizations including labour, farm, consumer, mental health organizations, chambers of commerce, women's institutes, individual laymen, wives of doctors, the medical schools of the province, individual sections of the OMA, the College of Physicians and Surgeons of Ontario, hospital organizations and allied health occupations.

In addition, a large number of lengthy interviews were conducted with senior officials in the public service, representatives of the news media, the academic and hospital fields, and with interns and members of the medical profession not identified with the administration of the association. Information and advice has been sought wherever it would be helpful. Without in any respect taking away from my own responsibility in this report, many of the views and proposals expressed in it have undergone robust criticism from competent independent citizens.

Dilemma

One of the ironies of the present situation is that all three of the principal parties involved in OHIP — the government, the public and the doctors — find themselves in a position which none of them deliberately planned or desired.

The Government of Ontario would no doubt have preferred an evolutionary development of universal hospital and medical coverage. But, under pressure familiar to all, it embarked upon medicare almost overnight, without time for adequate preparation of the services required to administer it. It is now criticized because standards of service have not reached the levels anticipated. Costs have been greater than expected. The government finds itself in the unhappy position of having to cut back on hospital and medical costs, something surely that politicians would prefer not having to do.

The public expected overnight an instant medical service on demand (characterized by one doctor as "instantomania") and today is justly dissatisfied with levels of service in many important respects. The public feels it is paying for medicare but not getting efficient service.

Let us consider the position in which the profession finds itself in Ontario today. Certainly the present is a time of frustration for many Ontario doctors. Their pioneer and highly responsible prepaid medical schemes were abruptly terminated when medicare was introduced. Now that many of the problems of cost, abuse and shortage of service predicted by the profession are coming all too true, it finds itself in the role of scapegoat.

For generations doctor travelling in a buggy was general practitioner, surgeon, midwife, pharmacist, psychiatrist, philosopher, friend

If doctors respond to the vastly increased demands for medical service and put in a six-day work week and hours greatly in excess of those of the ordinary worker, and in so doing, earn a substantial income, they are accused of being mercenary. They often find themselves subject to gross misrepresentation in the news media.

Doctors' views

For generations, the doctor, travelling in his buggy or motor car, was general practitioner, surgeon, midwife, pharmacist dispensing medicines from his satchel, psychiatrist, counsellor, philosopher, friend. Under the impact of an explosive medical and scientific revolution the modern doctor has had to divide and subdivide into innumerable specialties and finds it difficult to keep abreast of technological change. He is now accused, with some justification, of being remote and impersonal, and at times of being inaccessible and even arrogant.

Before the advent of insured medical plans and medicare, the doctor himself determined what he could and should charge his patients in the light of their ability to pay and the degree of his time and skill involved. He provided a good deal of free medical care and forgave a substantial part of the billings he rendered. Through no fault of his own, the system was totally changed and he is now expected to bill mechanically in accordance with a complex schedule. Unless he is a non-participating physician, he is no longer able to use his own judgement and discretion in deciding how much to bill.

Not so many years ago a doctor could use his own common sense in deciding how serious were the ailments of his patients and how he should divide his time among them, subject to the risk of losing some patients and consequent income. Under socialized medicine doctors are expected to provide medical services to everyone who wants them, irrespective of need.

A generation or two ago, the doctor was a highly honoured man in the community. A good part of his reward came from the personal satisfaction of exercising his professional skills according to his own judgement and conscience, in an environment that was sympathetic to him and encouraging of his labour. Today, the majority of doctors are as conscientious and as scrupulous as their predecessors and as hard working; but they are subject to criticism sometimes justified, and sometimes uninformed and unfair.

In many respects they are victims of a society being assaulted by urban growth, technological change and the ills of affluent, permissive and self-indulgent behaviour. The physician today stands in some danger of becoming the professional pariah of contemporary sociey.

It is not surprising that many doctors feel they are caught between the upper and the nether millstones of the public and government.

Nor should we forget that the doctor, no less than his patient, is human too. He has pretty much the same hopes and frailties as the rest of us. He marries, hoping to make a success of his marriage and bring up his children in a happy family environment, but the demands on his time make it increasingly difficult for him to fulfil his family role. Like the rest of us, he carries a load of personal and family anxieties but, unlike the rest of us, he carries the additional burden of anxieties for many of his patients. He is tired at the end of a long, hard day but often is expected to perform willingly and competently far into the night. He needs sleep as we all do but for many of the profession, rest is broken and uncertain.

A view frequently expressed at the public hearings was that, generally speaking, doctors are hard-working, competent, dedicated men and women of good character and repute. The primary physician is generally regarded as working long and indeed excessive hours, cutting seriously into family let alone social and community life and even interfering with the upgrading of his professional training and skills. A spokesman for a large group of women's organizations commented that the doctors in their communities were "competent, compassionate and ethical".

It is the purpose of this report to suggest ways and means by which the profession can make its performance more satisfactory to the public, and in so doing make it more rewarding to doctors themselves.